Open Enrollment Guide
Plan Year 2013

State of Nevada

Public Employees' Benefits Program

What's Inside:

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Effective July 1, 2012 - June 30, 2013

Plan Year 2013 Open Enrollment

DEADLINE FOR OPEN ENROLLMENT SUBMISSIONS
MAY 31, 2012

Supporting documents to add dependents must be received in the PEBP office by June 30, 2012

PEBP Member Services
(775) 684-7000 or (800) 326-5496
Monday - Friday (except holidays) 8:00 a.m. to 5:00 p.m.
Email: mservices@peb.state.nv.us

Introduction to

Open Enrollment

May 1 - May 31, 2012

Dear PEBP Participant:

During last year's open enrollment period, we provided information regarding several changes to PEBP's health plans. For Plan Year 2013, there are no significant changes in plan design; however, on the next few pages you will find a summary of the changes you can expect on July 1, 2012. For the new premium rates, please turn to pages 26 - 32.

Open enrollment will be held May 1 through May 31, 2012 and provides you the opportunity to evaluate your benefits and review plan design changes that will occur for the next plan year. This is also a good time to update your contact information with PEBP and review the voluntary benefit options available to you.

We encourage you to review and consider the information provided in this 2013 Open Enrollment Guide carefully. Should you have any questions or would like to request clarification on any of the plan options, PEBP's member service representatives can assist you. Please call 775-684-7000, 800-326-5496 or email mservices@peb.state.nv.us.

PEBP's Commitment to you:

- Provide you and your family with affordable and comprehensive health plan choices such as the Consumer Driven PPO High Deductible Health Plan, Health Plan of Nevada and Hometown Health HMO Plan.

- Evaluate future plan offerings and continually look for ways to enhance our benefit offerings.

The information in this guide is for informational purposes only. Any discrepancies between the benefits described herein and the PEBP Master Plan Document or the HMO Plan's Evidence of Coverage Certificates shall be superseded by the plan's official documents.

Allowable Changes

Important note: If you have a spouse or domestic partner covered on your plan who is eligible for coverage through their own employer, you must remove them from your PEBP coverage.

Changes you can make using the e-PEBP Online Enrollment tool at www.pebp.state.nv.us

- ☐ Change health plan options
- ☐ Add or drop a dependent (not a domestic partner)
- ☐ Change your Health Savings Account (HSA) beneficiary designation
- ☐ Elect or change contributions to your HSA
- ☐ Establish a HSA (new CD PPO HDHP employees effective July 1, 2012, or eligible employees who defaulted to the PPO Health Reimbursement Arrangement in July 2011).
- ☐ Establish a PPO HRA
- ☐ Update contact information

Changes you cannot make using the e-PEBP Online Enrollment tool

- ☐ Enroll in Medical Flexible Spending
- ☐ Enroll in Dependent Care Flexible Spending Account
- ☐ Enroll in voluntary products
- ☐ Cancel voluntary products
- ☐ Initial enrollment in retiree coverage
- ☐ COBRA enrollment
- ☐ Domestic Partner Enrollment
- ☐ Participant name change
- ☐ Moving outside coverage area

Your Responsibilities

- Understand that if you do not make any changes during Open Enrollment, your current plan option, dependent coverage and HSA contribution (if any) will remain in effect July 1, 2012, and you will pay the designated premium for your coverage.
- If you are making changes during Open Enrollment, be sure your election is submitted online, or if completing the paper form, that it is received by the PEBP office, or postmarked by May 31, 2012.
- If you are adding dependent(s) to your coverage, you must provide required supporting eligibility documentation to the PEBP office by June 30, 2012.
- You must notify PEBP within 30 days of a change to your address.
- Notify PEBP about any family status changes during the year that affects your benefits, such as birth, divorce, or marriage within 60 days of the event.
- Understand that family status changes not received within 60 days of the date of the event will be denied.
- If you *decline* coverage for yourself and/or your dependents, you will NOT be eligible to enroll in a medical plan until the next Open Enrollment period unless you have a qualifying family status change as defined in the Plan Year 2013 Master Plan Document available at www.pebp.state.nv.us.
- If you are currently paying for a voluntary Life Insurance policy or Short-Term Disability policy through The Standard and you decline your PEBP coverage during open enrollment, or any other time, these voluntary policies will also terminate.

How to Enroll

Complete your enrollment by doing one of the following:

1. Complete your enrollment online

Log on to the PEBP website at www.pebp.state.nv.us and click on Enroll Now. Follow the instructions to complete your enrollment.

All participants are encouraged to enroll online. Enrolling online will simplify your enrollment process and you will not have to complete the Open Enrollment Form. If you are enrolling in the CD PPO HDHP, you can also amend or elect your HSA contribution. If you are making changes you must enroll by May 31, 2012.

Or

2. Complete the Open Enrollment Form

- If you did not receive a form with your Open Enrollment letter, you may contact the PEBP office to request the Open Enrollment Form at 775-684-7000 or 800-326-5496.
- If you are completing the paper version of the form, you must return the completed form to the PEBP office by May 31, 2012 or postmarked by May 31, 2012.

Enrolling Dependent(s)

To add new dependents effective July 1, 2012, you must add them to your Open Enrollment election through online enrollment or include their information on the Open Enrollment form. Note: If you wish to add a domestic partner, you must complete the paper form available by calling 775-684-7000 or 800-326-5496.

Documentation to Add Dependent(s)

To *add* a spouse or domestic partner, submit a copy of your marriage certificate or a copy of your domestic partner certificate issued from the Nevada Secretary of State's office. To cover children from birth to age 26, submit a copy of the child's birth certificate. If the dependent is your stepchild or the child of your domestic partner, you must also provide a copy of your marriage certificate or domestic partner certificate. Supporting documentation to determine a dependent's eligibility for coverage must be received in the PEBP office by June 30, 2012.

For more information regarding supporting document requirements, please visit www.pebp.state.nv.us or call 775-684-7000, 800-326-5496 or email mservices@peb.state.nv.us.

Health Savings Account (HSA)

Employees who are currently self-contributing to their HSA through payroll deductions will continue making these same deductions (if continuing coverage under the CD PPO HDHP) after July 1, 2012. **Exception**: **Employees who complete an online enrollment change will automatically reset their election on July 1, 2012 to $0.00, unless a new contribution amount is elected when completing the online open enrollment event**.

Overview of Changes for Plan Year 2013

Consumer Driven PPO High Deductible Health Plan (CD PPO HDHP)

PPO Diabetes Care Management Program

The *Diabetes Care Management Program* is a disease management program open to all primary CD PPO HDHP participants, their covered spouses/domestic partners, and beginning July 1, 2012, their dependent children diagnosed with diabetes. The program provides you with a nurse health coach who will work with you on things such as your medications, health questions, blood glucose monitoring, foot and eye care, and other ways you can effectively manage your health.

Adults over age 18 who are participating in the Diabetes Care Management Program and who are considered "actively engaged" by HealthSCOPE Benefits and U.S. Preventive Medicine (USPM) will receive expanded benefits by adhering to the following:

- Performing daily monitoring/journaling of blood glucose levels; reporting results to your physician and USPM health coach
- Carrying a diabetes alert identifier in the event of an emergency
- Taking medications and/or daily aspirin therapy as prescribed by your physician

Children ages 1 - 18 will be considered "actively engaged" when adhering to the following:

- Completing at least 2 visits with their primary care physician or endocrinologist each plan year
- Completing appropriate lab testing each plan year
- Routinely taking medications as prescribed by their physician

Qualifying benefit enhancements for being actively engaged:

- Annually, receive two physician's office visits (with a primary diagnosis of diabetes) and two routine laboratory blood tests (e.g. hemoglobin (A1c) test) paid at 100%.
- Pay flat copayments for diabetes-related medications such as insulin or Metformin.
- Retail Prescription Drugs - 30 Day Supply/90 Day Supply
  - Generic: $5 copay -30 day supply or $15 copay - 90 day supply
  - Preferred Brand: $25 copay - 30 day supply or $75 copay 90 day supply

* Benefit enhancement will not apply to non-Preferred Brand medications.

- Diabetic Supplies
  - Receive valuable savings on diabetic supplies such as alcohol pads, test strips, syringes, lancets, etc. Purchase each 90-day supply item for a $50 copayment (or less if the actual cost is less). Supplies must be coordinated through Catalyst Rx and their vendor partner Liberty.

Overview of Changes for Plan Year 2013, Continued

CD PPO HDHP

Obesity Care Management

Effective July 1, 2012, the CD PPO HDHP will offer an Obesity Care Management Program to participants and their covered dependents who meet specific health-related eligibility criteria. Participants who are deemed actively engaged in the program by USPM and HealthSCOPE Benefits will receive expanded weight loss benefits paid at 100%; eligible expenses will not be subject to deductible or coinsurance (exceptions will apply to pharmacotherapy and meal replacements).

Active engagement in the program requires participation in the Live Well, Be Well Prevention Plan, regular office visits with a weight loss medical provider, adherence to the provider's treatment plan and a demonstrated consistent commitment to weight loss, including, but not limited to, routine exercise, proper nutrition and diet, and pharmacotherapy (if prescribed). For a detailed description of the Obesity Care Management Program, refer to the Plan Year 2013 Master Plan Document available at www. pebp.state.nv.us.

Weight Loss Surgeries and Plan Restrictions effective July 1, 2012

Weight loss surgeries (e.g. lap band and gastric bypass) must be performed at an in-network (PPO) outpatient or inpatient *Center of Excellence* facility, this restriction also applies to surgeons and other ancillary providers. The plan restricts one obesity related surgical procedure of any type in an individual's lifetime. For more information, refer to the Plan Year 2013 Master Plan Document at www. pebp.state.nv.us.

Travel expenses for Organ and/or Tissue Transplant and Obesity Surgery Services

Provide reimbursement of certain travel and hotel accommodation expenses for the patient and one additional individual person (spouse/domestic partner, family member or friend) when associated with medical treatment for organ and tissue transplants, and obesity surgery services are performed at a Center of Excellence. Limitations apply to this benefit, for detailed information regarding these plan restrictions, refer to the PlanYear 2013 Master Plan Document at www. pebp.state.nv.us.

National Preferred Provider Network

Effective July 1, 2012, the current national preferred provider network (Beech Street) will be replaced by GWH-CIGNA for participants residing *outside* of Nevada. Participants residing outside Nevada to travel to Nevada for healthcare will access healthcare using the Statewide PPO Network. Participants residing in Nevada who wish to access healthcare outside Nevada will use the First Health Network
Refer to page 34 for contact information.

Plan Year 2013 Dental Plan Benefits (for CD PPO HDHP and HMO participants)

The PPO Dental Plan's Preventive care benefit (e.g. four teeth cleanings, bitewing X-rays) will be paid at 100% when using in-network dental providers. This is in addition to the $1,000 annual maximum for Basic and Major services.

Overview of Changes for Plan Year 2013, continued

CD PPO HDHP Medical ID Cards

CD PPO HDHP participants will receive a new medical ID on or about July 1, 2012. Current participants continuing coverage under the CD PPO HDHP on July 1, 2012 may continue to use their current medical ID card pending receipt of the new card. Participants who are accessing healthcare outside Nevada will need to confirm whether or not their provider is contracted with the new CD PPO HDHP national network by calling HealthSCOPE Benefits at 888-763-8232.

One-time Supplemental HSA and HRA Contribution

Primary participants and their covered dependents enrolled in the CD PPO HDHP on July 1, 2012 will receive a one-time increase to their HSA and HRA funding. For details about the contribution amounts and eligibility, refer to page 17.

Live Well, Be Well (LWBW) Prevention Plan

This program provides an online portal that you can use 24/7 to get healthy or stay healthy. It features a broad range of educational materials, such as health and wellness webinars, a comprehensive medical library with reliable resources where you can learn about nutrition, healthy living, medical tests and procedures, health and wellness activities, various disease states, illness, and more. Participants have access to a confidential health journal to track physician office visits, lab results, medications, and more. The program offers a Health Assessment Questionnaire (HAQ) that will identify a person's five highest health risks. Any information you entered into the personal profile is completely confidential.

The program is offered to primary participants, their covered spouses/domestic partners and children enrolled in the CD PPO HDHP beginning July 1, 2012.

- Returning LWBW primary participants (who enrolled in the program last fall by October 31, 2011) had until February 29, 2012 to build their Intervention Score. Premium reductions effective July 1, 2012 are based on the total Prevention Score and may be found on page 7. The registration period for those who wish to continue the LWBW Prevention Plan and new participants who wish to enroll for Plan Year 2013 will have until May 15, 2012 to register, complete the biometric screening and the HAQ. Completing these three steps will allow primary participants to earn an additional $5 premium reduction effective July 1, 2012 and the opportunity to start building their Prevention Score to earn premium credits for Plan Year 2014, effective July 1, 2013. Premium reductions will not apply to dependents of primary participants.

- Participants who change from an HMO plan to the CD PPO HDHP during the open enrollment period will be eligible to enroll in the LWBW Prevention Plan in late June after their open enrollment election has been processed. The enrollment period for these participants will end August 15, 2012. Primary participants who complete registration, lab work and the HAQ during this period will be eligible to receive a $5 premium credit beginning October 1, 2012. This will allow them to start building their Prevention Score toward a premium incentive for Plan Year 2014, effective July 1, 2013.

Overview of Changes for Plan Year 2013, continued

Live Well, Be Well (LWBW) Prevention Plan

- New hires whose coverage becomes effective June 1 through August 1, 2012, and who enroll in the CD PPO HDHP will be eligible to enroll in the LWBW Prevention Plan in late June after their new hire paperwork has been processed. The enrollment period for these participants will end August 15, 2012. Primary participants who complete registration, lab work and the HAQ during this period will be eligible to receive a $5 premium credit beginning October 1, 2012.

To learn more about the LWBW Prevention Plan, visit:
http://nevadapebp.thepreventionplan.com/

The following table provides the point range of the LWBW Prevention Plan and related premium reduction incentives for primary CD PPO HDHP participants who completed the *Intervention* phase (through February 29, 2012) and the spring *Assessment* phase ending May 15, 2012.

If final Prevention Score falls in this range:	Receive this monthly premium reduction:	Bonus monthly premium reduction earned by completing HRA & biometric screening in Spring 2012	Total monthly premium reduction earned July 1, 2012
0-400	$0	$5	$5
401-500	$5	$5	$10
501-600	$10	$5	$15
601-700	$20	$5	$25
701-800	$30	$5	$35
801-1,000	$40	$5	$45

Health Plan of Nevada (HPN)

HPN's emergency room visit copayment will change to $75 copayment per visit.

Hometown Health Plan (HHP)

Hometown Health Plan will not have any plan design changes for Plan Year 2013

Health Plan Options

Consumer Driven PPO High Deductible Health Plan (CD PPO HDHP)

The CD PPO HDHP includes a $1,900 individual and $3,800 family deductible. This plan is coupled with a HSA or a PPO-HRA to help offset out-of-pocket healthcare expenses. The plan is designed so all eligible medical and pharmacy expenses are subject to the annual deductible. The CD PPO HDHP offers wellness benefits (only when services are accessed through in-network providers) based upon guidelines published by the Centers for Disease Control and Prevention (CDC).

The plan year out-of-pocket maximum (in-network) for an individual is $3,900 and $7,800 for a family. Participants enrolled in the CD PPO HDHP have access to a Statewide PPO network, as well as a national network.

Health Plan of Nevada (HPN) HMO

Health Plan of Nevada is a Health Maintenance Organization (HMO) where members can access dependable care at fixed copayments. HPN offers a wide selection of physicians, hospitals, pharmacies and other healthcare providers. The service area includes Clark, Esmeralda, and Nye Counties (available in Lincoln County for participants who reside in the following zip codes: 89001, 89008, and 89017). HPN requires that you select a primary care physician (PCP) when enrolling in this plan. To select a primary care physician, or to view HPN's Evidence of Coverage, visit www.pebp.state.nv.us, or contact HPN at (702) 242-7300 or (800) 777-1840.

Hometown Health Plan (HHP) HMO

Hometown Health is a HMO that offers fixed copayments for primary care, specialty, and urgent care visits. The plan features medical, prescription drug, and vision coverage. Medical services must be received from a network provider. This plan requires that you select a primary care provider (PCP) at initial enrollment. Hometown Health Plan offers its members Open Access. This means you can self-refer yourself to select contracted specialists without first obtaining a referral from your PCP. It is offered to participants residing in Carson City, Churchill, Douglas, Elko, Eureka, Lander, Lincoln, Lyon, Humboldt, Mineral, Pershing, Storey, Washoe, and White Pine Counties. To select a PCP, or to view the HHP Evidence of Coverage Certificate, visit www.pebp.state.nv.us, or contact HHP at (775) 982-3232 or (800) 336-0123.

HMO Reciprocity

Participants enrolled in *Hometown Health Plan* or *Health Plan of Nevada* are eligible for expanded statewide provider access. These plans have a special network reciprocity agreement that allows HMO members to utilize both networks under certain circumstances. Reciprocity applies when traveling to/from northern/southern Nevada, and for dependents who are away at school in either the northern or southern part of the state. Expanded access is based on the primary participant's designated HMO plan provisions. The designated plan's pre-authorization requirements and referral guidelines still apply as described in the specific HMO plan document.

Medical Plan Comparison

Benefit Category	CD PPO HDHP	Health Plan of Nevada HMO	Hometown Health Plan HMO
	Amount You Pay In-Network	**Amount You Pay In-Network**	**Amount You Pay In-Network**
Medical deductible	$1,900 individual $3,800 family • $2,400 Individual - when two or more family members covered	No deductible	No deductible
Out-of-pocket maximum	$3,900 person $7,800 family (per plan year)	$6,800 person (per calendar year)	$6,200 person $12,400 family (per plan year)
Hospital inpatient	25% coinsurance after deductible	$200 copayment per admission	$1,500 per admission
Outpatient Same Day Surgery	25% coinsurance after deductible	$50 copayment per admission	$1,000 copayment per admission
Primary care visit	25% coinsurance after deductible	$15 copayment	$25 copayment
Specialist visit	25% coinsurance after deductible	$15 copayment	$45 copayment
Urgent Care visit	25% coinsurance after deductible	$15 copayment	$50 copayment
Emergency room visit	25% coinsurance after deductible	$75 copayment, waived if admitted	$300 copayment per visit
General laboratory services	25% coinsurance after deductible	No charge	No charge for outpatient or hospital
Chiropractic services	25% coinsurance after deductible	$15 copayment per visit	$45 copayment per visit $1,000 plan year max
Wellness/ Prevention	No charge for eligible wellness benefits provided in-network	No charge	No charge
Vision exam	25% coinsurance, U& C* after deductible	$10 copayment every 12 months	$15 copayment every 12 months
Vision hardware (frames, lenses, contacts)	No benefit	$10 copayment/ lenses frames - $100 allowance, contacts $115 in lieu glasses	15 to 20% discount

*** Usual and Customary Charge (U&C):** The charge for medically necessary services or supplies as determined by HealthSCOPE Benefits to be the prevailing charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply.

Pharmacy Plan Comparison

Benefit Category	CD PPO HDHP	Health Plan of Nevada HMO	Hometown Health Plan HMO
	Amount You Pay In-Network	Amount You Pay In-Network	Amount You Pay In-Network
Plan Deductible	$1,900 individual $3,800 family • $2,400 Individual -when two or more family members covered	No deductible	No deductible
Out-of-pocket (OOP) maximum	$3,900 person $7,800 family (per plan year)	Contact HPN for pharmacy OOP* maximum	Contact HHP for pharmacy OOP* maximum
Retail Pharmacy - 30 day supply			
Preferred Generic (Tier 1)	25% after deductible	$7 copayment	$7 copayment
Preferred Brand (Tier 2)	25% after deductible	$35 copayment	$40 copayment
Non-Formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	$55 copayment	Greater of $75 copayment per script or 40%
Specialty Drugs	25% after deductible - available in 30 day supply only through Walgreen pharmacies	Applicable retail pharmacy copayment will apply	30% coinsurance
Mail Order - 90 day supply			
Preferred Generic (Tier 1)	25% after deductible	$14 copayment	$14 copayment
Preferred Brand (Tier 2)	25% after deductible	$70 copayment	$80 copayment
Non-formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	Not available through mail order	Greater of $150 copayment per script or 40%
Specialty Drugs	25% after deductible, available in 30 day supply only through Walgreens mail order	Applicable retail pharmacy copayment applies	Not available through mail order

Out-of-Pocket Maximum (OOP): The maximum amount of coinsurance each covered person or family is responsible for paying during a plan year before the coinsurance required by the plan cease to apply. When the OOP maximum is reached, the plan will pay 100% of eligible covered expenses for the remainder of the plan year.

CD PPO HDHP

About the CD PPO HDHP	The Consumer-Driven PPO High Deductible Health Plan is an insurance plan that allows you as a participant to use a Health Savings Account (HSA) or PPO Health Reimbursement Arrangement (PPO-HRA) to pay certain healthcare expenses directly, while the high deductible health plan protects you against catastrophic medical expenses.	
Plan Feature	**In-Network (participating provider benefit)**	**Out-of-Network Benefit**
Annual Deductible *Copayments for physician's office visits and prescription drug coverage do not apply to this plan.*	$1,900 Individual $3,800 Family[1] • $2,400 Individual Family Member Deductible	$1,900 Individual $3,800 Family[1] • $2,400 Individual Family Member Deductible
Annual Out-of-Pocket Maximum (Participant pays)	$3,900 Individual[2] $7,800 Family[2]	$10,600 Individual[3] $21,200 Family[3]
Includes annual deductible and coinsurance; excludes any charges in excess of Usual and Customary (U&C)[3] charges when accessing services from out-of-network providers.		

Each plan year, before the plan begins to pay benefits, you are responsible for paying all of your eligible medical and prescription drug expenses up to the plan year deductible. Eligible medical and prescription drug expenses are applied to the deductibles in the order in which claims are received by the plan. Only eligible medical and prescription drug expenses can be used to satisfy the plan's deductibles. Non-eligible medical and prescription drug expenses described in the following sections do not count toward the deductibles. Deductibles accumulate on a plan year basis and reset to zero at the start of each new plan year.

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[1] Family Deductible: The $3,800 Family Deductible applies when two or more individuals are covered on the plan. Embedded in the Family Deductible is a $2,400 Individual Family Member Deductible (IFMD). With the IFMD the plan will begin to pay benefits for one individual in the family once that person meets the $2,400 IFMD. The balance of the Family Deductible ($1,400) must be met by one or more other members of the family before the plan will pay benefits for those other family members.

[2]Out-of-Pocket Maximum: The plan will pay 100% of eligible charges once the annual out-of-pocket maximum has been met through deductible and coinsurance. A single individual within a family can be responsible for the entire out-of-pocket maximum.

[3] Services provided out-of-network are subject to U&C provisions, meaning charges are subject to the maximum allowance under the plan and covered individuals will be responsible for any amount the providers charge in excess of the maximum allowance.

CD PPO HDHP, continued

Medical deductibles and coinsurance for individual or family coverage accumulate separately for in-network and out-of-network expenses. If both in-network and out-of-network providers are used, the deductible will have to be met twice - once for in-network and once for out-of-network.

The following example describes how the in-network "Individual Family Member Deductible" works with the Family Deductible when two or more individuals are covered under the plan:

1.Family member #1 incurs $2,500 in eligible in-network medical expenses, of which $2,400 is applied to the individual in-network deductible and $2,400 is also applied to the family deductible of $3,800. In this example, the individual has met his or her in-network deductible and the remaining in-network family deductible is $1,400. The remaining $100 is paid at the appropriate coinsurance rate which is generally 75%.

2.Family member #2 incurs $2,000 in eligible in-network medical expenses: $1,400 is applied toward the remaining family in-network deductible, which satisfies the $3,800 annual family in-network deductible amount. The remaining $600 is paid at the appropriate coinsurance rate.

For more information, refer to the Plan Year 2013 Master Plan Document at www.pebp.state.nv.us.

CD PPO HDHP, continued

Plan Feature	In-Network (participating provider) benefit	Out-of-Network Benefit
Coinsurance (Plan pays)	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Primary Care Physician (PCP) *PCP includes internists, general and family practitioners, pediatricians and obstetricians/gynecologists.*	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Specialist Office Visits	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Outpatient Short-Term Rehabilitative Therapy • Occupational therapy • Physical therapy • Speech therapy	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Emergency Care • Emergency Room Visit • Ambulance Services	• 75% after deductible	• 75% after deductible, Usual and Customary* applies.
Urgent Care	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Outpatient Laboratory Services • Outpatient laboratory services (except for pre-admission testing, urgent care facility or emergency room) performed at an acute care hospital will not be covered unless an exception is warranted and approved by the Plan Administrator. • If an outpatient laboratory facility or draw station is not available to you within 50 miles of your residence, you may use an acute care hospital to receive your outpatient laboratory services.	• 75% after deductible when testing performed at an independent free-standing laboratory.	• 50% after deductible, Usual and Customary* applies.

*** Usual and Customary Charge (U&C):** The charge for medically necessary services or supplies as determined by HealthSCOPE Benefits to be the prevailing charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply.

CD PPO HDHP, continued

Plan Feature	In-Network (participating provider) benefit	Out-of-Network Benefit
Temporomandibular Joint Disorder (TMJ)	• 50% after deductible	• 50% after deductible, Usual and Customary* applies.
Prevention/Wellness For example (not all inclusive): • Physical exam, screening lab and x-rays • Well child visits and age appropriate immunizations • HPV vaccination • Prostate screening • Routine sigmoidoscopy or colonoscopy • Screening mammogram (in the absence of a diagnosis) • Pelvic exam and Pap smear lab test • Osteoporosis screening • Hypertension screening • Skin Cancer Screening • Routine hearing exam	• 100% - No deductible	• Not covered
Vision Exam	75% after deductible Usual and Customary* applies.	75% after deductible Usual and Customary* applies.

*** Usual and Customary Charge (U&C):** The charge for medically necessary services or supplies as determined by HealthSCOPE Benefits to be the prevailing charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply.

For a detailed description of benefits, refer to the Plan Year 2013 Master Plan Document available at www.pebp.state.nv.us

Health Savings Account (HSA)
For Eligible Active Employees

The Health Savings Account (HSA) is a tax-exempt trust or custodial account that is established through HealthSCOPE Benefits to reimburse certain qualified medical expenses you incur. You must meet certain eligibility requirements for an HSA.

Benefits of an HSA

- Employer (PEBP) contributions are excluded from gross income
- Optional employee contributions through pre-tax payroll deductions
- Employee contributions excluded from gross income
- Employee contribution may be started, increased, decreased or stopped at any time
- Distributions are tax-exempt when used to pay qualifying healthcare expenses
- Interest bearing account and investment options
- Unused dollars carry over from year to year
- Employee owned account (will remain with the employee at termination, retirement, or change of health plans)
- HSA funds may be used for current and future healthcare expenses
- **Optional additional $1,000 contribution by employees 55 or older at the end of the tax year**
- May be used to pay for qualifying healthcare expenses for other members of the tax-family, whether or not they are covered on the employee's health plan.

Qualifying for the HSA

- You must be covered under the CD PPO HDHP;
- No secondary coverage permitted (Medicare, Tricare, Tribal, HMO, etc.) unless the secondary coverage is also a high deductible health plan
- You *cannot* be claimed on someone else's tax return (excludes joint returns), or your spouse has a Medical FSA or an HRA that can be used to pay for your medical expenses
- You cannot be covered under COBRA

When you complete the Open Enrollment process (online/paper form), you must certify whether or not you are eligible for the HSA.

HSA 2012 calendar year maximum limit:

- Individual: $3,100
- Family (two or more): $6,250
- Optional additional $1,000 contribution by employees 55 or older at the end of the tax year

Note: The above limits must be reduced by PEBP's HSA contribution amount.

For PEBP contribution amounts see page 17.

CD PPO HDHP Health Reimbursement Arrangement (HRA)

For retirees and certain active employees enrolled in the CD PPO HDHP

The PPO-Health Reimbursement Arrangement (PPO-HRA) is an employer-owned account establish on behalf of eligible participants (for primary participants enrolled in the CD PPO HDHP and who are not eligible for the HSA), see page 15 for eligibility requirements.

PPO-HRAs may be used to pay for qualified healthcare expenses for the participant and members of the participant's tax-family. PPO-HRAs are owned by PEBP and participant contributions are not allowed. If the participant is no longer covered under the CD PPO HDHP (terminates employment, declines coverage or passes away) any remaining funds in the HRA are returned to PEBP.

For more information regarding the PPO-HRA, please refer to the Plan Year 2013 Master Plan Document at www.pebp.state.nv.us.

To determine HRA contributions for active employees, turn to page 17. Retirees enrolled in the CD PPO HDHP will receive HRA contributions as shown below:

HRA Contribution for Retirees Enrolled in the CD PPO HDHP			
Base individual contribution	**One-time supplemental contribution for individuals effective July 1, 2012**	**Total Primary Participant contribution**	**Additional one-time contribution for retirees with 20+ years of service on July 1, 2012**
$700	$400	$1,100	$200
Base dependent contribution	**One-time supplemental contribution for covered dependents effective July 1, 2012**	**Total contribution per dependent (maximum 3 dependents)**	
$200 per dependent (spouse/domestic partner or child) maximum 3 dependents	$100 per dependent (spouse/domestic partner or child) maximum 3 dependents	$300 per dependent (spouse/domestic partner or child)	

HSA and HRA Contribution for Active Employees Enrolled in the CD PPO HDHP			
Base individual contribution	**One-time supplemental contribution for individuals effective July 1, 2012**	**Total primary participant contribution**	**Additional one-time contribution for primary participants aged 45 or older on June 30, 2012**
$700	$400	$1,100	$200
Base dependent contribution	**One-time supplemental contribution for covered dependents effective July 1, 2012**	**Total contribution per dependent (maximum 3 dependents)**	
$200 per dependent (spouse/domestic partner or child) - maximum 3 dependents	$100 per dependent (spouse/domestic partner or child) - maximum 3 dependents	$300 per dependent (spouse/domestic partner or child)	
HSA contribution maximum for calendar year 2012*		**Individual**	**Family (two or more family members)**
The maximum shown is for eligible HSA individuals with high deductible health coverage through December 31, 2012[1]		$3,100	$6,250[2]

[1]The total 2012 contributions (combined employee/employer) cannot exceed the limits shown.

[2]The Family maximum is based on your family as reported to the IRS on your federal tax return and applies regardless of whether two employees are married and eligible for the HSA. For example, if one employee is covering a dependent and the other employee is covered as self-only, the maximum for the entire family is $6,250; therefore, the total combined contributions between both employees and PEBP's contribution cannot exceed $6,250.

To be eligible for the family maximum, the employee and at least one other dependent on the federal tax return must be eligible for the HSA.

Note: If an employee is covering a dependent and that dependent has other coverage that is not considered a high deductible health plan, the maximum contribution allowed by IRS for the employee is based on an Individual or $3,100.

*Maximum calendar year contribution limits are set by the Internal Revenue Service.

Note: New hires with coverage effective August 1, 2012 and later will receive a $700 prorated contribution and $200 prorated contribution for each dependent (maximum 3 dependents) based upon the coverage effective date and months remaining in the plan year.

Flexible Spending Account

Flexible Spending Accounts (FSA) are regulated by Section 125 of the IRS. FSAs are based on a calendar year (whereas your medical plan is based on a fiscal year from July 1, 2012 through June 30, 2013). To participate in flexible spending, you must enroll each year during open enrollment. Unless you become eligible to enroll mid-year due to a qualifying life status event. If you are thinking about enrolling in flexible spending, you will want to be sure you understand the IRS provisions for medical and dependent care flexible spending before making your election. The Flexible Spending Account Summary Plan Description is available under Publications on the PEBP website at www.pebp.state.nv.us.

You will pay a small fee of $3.50 per month to participate in either one or both flexible spending accounts. There is an additional annual fee of $18 for those selecting the convenience of a FSA debit card.

To enroll in flexible spending, you must be an active employee in one of the State of Nevada payroll centers and, enrolled in health benefits with active coverage through PEBP.

Note: Excludes the Nevada System of Higher Education employees who have a separate plan.

Medical FSA Maximum for Plan Year 2013

The Medical FSA Plan Year Maximum is $2,500 ($208.33 maximum *monthly* contribution or $96.15 per pay period for employees paid biweekly). Note: This is a per employee deduction limitation, not a household limitation. If an employee and his/her spouse are also eligible for the Medical FSA, each individual can establish their own Medical FSA with a $2,500 Plan Year maximum.

Dependent Care FSA 2012 - 2013 Calendar Year Maximum

The Dependent Care FSA calendar year limit is established by IRS. You and your spouse may *together* elect a maximum of $5,000 for both the 2012 and 2013 Tax Years (July 1, 2012 through June 30, 2013). If you are married and do not file a joint tax return, you can set aside up to $2,500 in a Dependent Care FSA.

If you are an active employee enrolled in the Consumer Driven PPO High Deductible Health Plan with a Health Savings Account, Federal rules do NOT allow you to enroll in a Medical FSA. However, you may enroll in the *Limited Scope* FSA which allows you to set aside pre-tax money for vision and dental expenses.

To participate in Flexible Spending, fax your enrollment election before May 31, 2012 to ASI Flex at 877-879-9038. Flexible Spending Account Enrollment Forms are available under the FORMS link at www.pebp.state.nv.us

For more information, contact ASI Flex at 800-659-3035 or visit www.asiflex.com.

	HSA CD PPO HDHP Participants	PPO-HRA CD PPO HDHP Participants	Exchange-HRA Extend Health Medicare Part A Retirees	Medical FSA*	Limited Purpose FSA
Who is eligible?	Certain employees in the CD PPO HDHP. See restrictions on page	Participants not eligible for an HSA	Medicare Part A retirees enrolled in a medical plan through Extend Health	State employees (HMO) **If you have an HSA, you may only enroll in a Limited Purpose FSA*	State employees only enrolled in the CD PPO HDHP with an HSA
Who may contribute?	Employer and employee	Employer only	Employer contributions only based upon retiree years of service.	Employee only	Employee only
What are the funding options?	Funded by PEBP and voluntary employee contributions	Employer funded, paid as incurred (no employee contributions permitted)	Employer funded through the retiree years of service	Funded through employee contributions	Funded through employee contributions
Will the balance carry over?	Yes	Yes, carry over balance determined by the PEBP Board	Yes, carry over balance determined by the PEBP Board	No, although grace period applies	No, although grace period applies
Is this fund account portable?	Yes	No. If the retiree/ employee is no longer covered by the CD PPO HDHP the funds are returned to PEBP	No. If the retiree is no longer covered by the Exchange the funds are returned to PEBP	No	No
Are there interest or investment earnings?	Yes	No	No	No	No
Are contributions taxable income to the employee?	Not if used for qualifying healthcare expenses	No	No	Not if used for qualifying healthcare expenses	Not if used for qualifying dental and vision care expenses

Dental Plan

All PPO and HMO Eligible Participants (optional for Exchange Retirees)

Benefit Category	In-Network	Out-of-Network
Plan year Maximum	$1,000 per person	$1,000 per person
Plan Year Deductible (applies to basic and major services only)	$100 per person or $300 per family (3 or more)	$100 per person or $300 per family (3 or more)
Preventive Services Four cleanings/plan year, exams, bitewing X-rays (2/plan year)	100% of allowable fee schedule, no deductible **Preventive services do not apply to plan year maximum**	80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the plan will reimburse at the U & C **Preventive services do not apply to plan year maximum**
Basic Services Periodontal, fillings, extractions, root canals, full-mouth X-rays	75% of allowable fee schedule, after deductible	50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the plan will reimburse at the U & C
Major Services Bridges, crowns, dentures, tooth implants	50% of allowable fee schedule, after deductible	50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the plan will reimburse at the U & C

- **Family Deductible: Could be met by any combination of eligible dental expenses of three or more members of the same family coverage tier**. No one single family member would be required to contribute more than the equivalent of the individual deductible toward the family deductible. Both in-network and out-of-network deductibles are combined to meet your deductible each plan year.

- **Under no circumstances will the combination of PPO in-network and PPO out-of-network services for Basic and Major benefit payments exceed the plan year maximum benefit $1,000**

Basic Life Insurance *All Eligible Primary Retirees and Employees*	
Employee Basic Life Insurance	Employees enrolled in a PEBP-sponsored medical plan receive $10,000 Basic Life Insurance coverage. Refer to the Life Insurance Certificate at http://*www*.standard.com/mybenefits/nevada for more information about this benefit or call The Standard at 888-288-1270.
Long-Term Disability for Active Employees	Long Term Disability Insurance is provided to active employees enrolled in a PEBP-sponsored medical plan. This benefit is designed to help protect you against a loss of income in the event you become disabled and are unable to work for an extended period of time. If your LTD claim is approved, benefits become payable at the end of the 180-day Benefit Waiting Period (no benefits are paid during the Benefit Waiting Period). The monthly LTD benefit is based on your earnings from the State of Nevada or participating public agency. Your monthly LTD benefit is 60 percent of the first $12,500 of your monthly earnings, as defined by the group insurance policy, reduced by deductible income. For more information about the LTD benefit, see the LTD Certificate of Insurance at
Retiree Basic Life Insurance	Retirees enrolled in the CD PPO HDHP, HMO plan or a qualifying medical plan through Extend Health receive $5,000 Basic Life insurance coverage. Refer to the Life Insurance Certificate at http://*www*.standard.com/mybenefits/nevada for more information about this benefit.
Medex Travel Assist for Active Employees and Retirees enrolled in the CD PPO HDHP, HMO Plan or a qualifying medical plan through Extend Health.	Medex Travel Assist is designed to respond to most medical care situations and many other emergencies you and your family experience when you travel 100 miles or more from your home. Medex provides a wide-ranging program of information, referral, coordination and assistance services. These services include pre-trip assistance, medical assistance, emergency transportation, travel and technical assistance, legal services and medical supplies. Assistance is available 24 hours a day, 365 days a year whether you are 100 or 10,000 miles away from your home. Simply print out and carry the Medex Travel Assist Card available at http://www.standard.com/mybenefits/nevada/life_add.html#ben

Voluntary Life Insurance

All Eligible Primary Retirees and Employees

Voluntary Life Insurance

The State of Nevada provides a basic amount of Life insurance to help protect your loved ones in the event of your death. Since everyone's needs are different, you also have the opportunity to apply for Voluntary Life insurance from Standard Insurance Company. Plus, your premiums can generally be deducted from your paycheck or from your PERS check (if applicable) for retirees. In certain circumstances, you may be required to provide satisfactory proof of evidence of insurability.

Active Employee	Voluntary Life Insurance may be elected in a multiple of $5,000 to a maximum of $50,000 with a minimum of $5,000 of coverage. Voluntary Life Insurance includes AD & D insurance from The Standard. With Voluntary Life and AD & D, you or your beneficiaries may be eligible to receive an additional benefit in the event of death or dismemberment as a result of an accident. If you are already insured for Voluntary Life, you may be eligible to increase your coverage during open enrollment without submitting evidence of insurability (provided the amount of your Voluntary Life coverage will not exceed $100,000). Contact Standard Insurance at 888-288-1270.
Retiree (Reinstated retirees are not eligible for Basic or Voluntary Life Insurance)	Voluntary Life Insurance may be elected in units of $5,000, to a maximum of $50,000 with a minimum of $5,000 of coverage. Requests for increases may require you to provide evidence of insurability. Contact Standard Insurance at 888-288-1270.

For information on premium rates and eligibility, please contact The Standard at (888) 288-1270 or visit www.standard.com/mybenefits/nevada/index.html.

IMPORTANT!

Participants who decline PEBP-sponsored coverage (CD PPO HDHP, HMO, or medical coverage through Extend Health) will not qualify for Basic or Voluntary Life Insurance.

Exchange Health Reimbursement Arrangement (Exchange-HRA)

For Medicare Retirees Enrolled in a Medical Plan Through Extend Health

Exchange Health Reimbursement Arrangements, or Exchange-HRAs, are PEBP-owned accounts established on behalf of PEBP retirees enrolled in a medical plan offered through Extend Health.

Retirees can use the Exchange-HRA for reimbursement of qualified healthcare expenses, including premiums for Medicare coverage, on a tax-free basis. Exchange-HRAs may also be used for reimbursement of a spouse's qualified healthcare expenses.

Retirees receive a contribution to their Exchange-HRA based upon their years of service. The monthly tax-exempt contribution amount is $10 per month per year of service beginning with five years ($50) to a maximum of twenty years of service ($200). Individuals who retired before January 1, 1994, will receive a flat $150 per month to the Exchange-HRA. Dependents do not receive their own Exchange HRA and no additional funds are contributed for dependents. Individuals hired after January 1, 2010, who retire with less than 15 years of service are not eligible for a contribution.

How it works:

Getting Reimbursed from your Exchange-HRA		
1. You pay premiums and expenses You pay the full premiums directly to your insurance provider (ask Extend Health about the auto-reimbursement option for premiums). You also pay your provider any required out-of-pocket expenses.	**2. You submit out-of-pocket expenses** You submit your claim to Extend Health for your premiums and out-of-pocket healthcare expenses.	**3. Extend Health reimburses you** Extend Health administers your account and will reimburse you from your Exchange-HRA if funds are available.

Exchange-HRA Plan Administrator

Extend Health is the Exchange-HRA plan administrator responsible for processing expense reimbursements for retirees.

Retiree Medicare Enrollment and Coverage Options

If you (the primary insured participant) are a **retiree with Medicare Parts A and B** and you also cover a spouse/domestic partner or child(ren) **without** Medicare Parts A and B, or if you are a retiree without Medicare Part A and B and you cover a spouse or domestic partner with Medicare Part A, you will have the option to combine or split coverage (see Options 2 and 3).

To determine your plan options, go to column A and choose who you wish to cover on July 1, 2012. Then go to column B and select your coverage option.

Column A Choose Who You Want to Cover	Column B Choose your Coverage Option
If you would like to cover: • *Only yourself and you are eligible for Medicare Part A and B,* refer to **Coverage option #1.**	**Option #1** **Extend Health** You must select a medical plan through Extend Health before June 30, 2012. If you do not select a medical plan through Extend Health by June 30, 2012, you will lose all PEBP coverage.
If you would like to cover: • Y*ourself and your spouse or domestic partner and you both are eligible for free Medicare Part A,* refer to **Coverage Option #1.**	
If you would like to cover: • *Yourself and one or more dependents and at least one person you are covering is not eligible for free Medicare Part A,* refer to **Coverage options #2 or #3** **After selecting your option from this page, turn to page 25 to find out what to do next.** **Declining Retiree Coverage** • Retirees have the option to decline coverage. By declining coverage, a retiree loses medical, dental, prescription drug, and Basic Life and Voluntary Life insurance coverage.	**Option #2** **PEBP's PPO/HMO Coverage** You *and* your spouse or domestic partner *and/or* child(ren) may remain on the CD PPO HDHP or an HMO plan. To continue PEBP coverage, you must complete the Open Enrollment Form (or go online at www.pebp.state.nv.us) before May 31, 2012. **Option #3** **Split Coverage -** Enroll in Separate Plans **(Extend Health &PEBP CD PPO HDHP/HMO)** Medicare Part A individual(s) may enroll in an individual medical plan through Extend Health. Individuals who are ineligible for Medicare Part A may select the CD PPO HDHP or an HMO plan by calling the PEBP office to request the Benefit Enrollment and Change Form.

Retiree Medicare Enrollment and Coverage Options

Select Your Coverage Option below	Your Next Steps - Actions You Must Take
Option #1 Enroll in coverage through Extend Health	**Option #1 - Extend Health** 1. Contact Extend Health to enroll for coverage before May 31, 2012 at 1-888-598-7545. 2. Complete the PEBP Open Enrollment Form (or complete your enrollment online at www.pebp.state.nv.us) by May 31, 2012. Select Extend Health with or without PEBP Dental.
Option #2 Enroll in the CD PPO HDHP or HMO Coverage	**Option #2 - PEBP's PPO/HMO Coverage** 1. Review the Open Enrollment Guide to learn about the plan changes and premium rates. 2. After learning about the plan options and costs of each plan, if you wish to select Option #2, complete item 3 in this list. 3. Complete the PEBP Open Enrollment Form (or complete your enrollment online at www.pebp.state.nv.us) before May 31, 2012.
Option #3 Enroll in Separate Plans Extend Health and either the CD PPO HDHP or an HMO plan	**Option #3 - Split Coverage** 1. Contact Extend Health at 1-888-598-7545 to learn about plan options and premium rates and review the Open Enrollment Guide to learn about the PPO and HMO plan changes/rates. 2. Complete the following: 3. To split coverage the Medicare Part A individual(s) (either the primary insured or the spouse/domestic partner) will contact Extend Health at 1-888-598-7545 to enroll in medical coverage. 4. You (the primary insured) must complete the PEBP Open Enrollment Form (or complete your enrollment online at www.pebp.state.nv.us) and select Extend Health *with or without* dental coverage. Return the form to PEBP by May 31, 2012. 5. If the non-Medicare individual is the spouse or domestic partner, contact PEBP to request the appropriate form to establish their PEBP account.

State Active Rates

Effective July 1, 2012 - June 30, 2013

State Active Employees	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Employee Only	44.93	134.75
Employee + Spouse	206.96	391.99
Employee + Child(ren)	96.31	246.59
Employee + Family	258.34	503.83

State Active with *Domestic Partner* Rates	Statewide PPO		
	Consumer Driven PPO High Deductible Health Plan		
	Participant Premium	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	206.96	44.93	162.03
Employee + DP's Child(ren)	96.31	44.93	51.38
Employee + Children of both	96.31	96.31	-
Employee + DP + EE's Child(ren)	258.34	96.31	162.04
Employee + DP + DP's Child(ren)	258.34	44.93	213.42
Employee + DP + Children of both	258.34	96.31	162.04

State Active with *Domestic Partner* Rates	Statewide HMO		
	Hometown Health Plan and Health Plan of Nevada		
	Participant Premium	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	391.99	134.75	257.24
Employee + DP's Child(ren)	246.59	134.75	111.84
Employee + Children of both	246.59	246.59	-
Employee + DP + EE's Child(ren)	503.83	246.59	257.24
Employee + DP + DP's Child(ren)	503.83	134.75	369.08
Employee + DP + Children of both	503.83	246.59	257.24

State Retiree Rates

Effective July 1, 2012 - June 30, 2013

State Retiree	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Retiree only	227.28	307.03
Retiree + Spouse	557.49	734.45
Retiree + Child(ren)	329.08	492.89
Retiree + Family	662.41	920.32
Surviving/Unsubsidized Dependent	631.32	602.01
Surviving/Unsubsidized Spouse + Child(ren)	813.12	863.79
Note: State retirees in the HMO in the "Retiree Only" coverage tier will not pay more than $602.01 per month after factoring in the appropriate Years of Service Subsidy. **To determine your final premium, turn to page 29.**		

State Retiree with *Domestic Partner* Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Retiree + DP	557.49	734.45
Retiree + DP's Child(ren)	329.08	492.89
Retiree + Children of both	329.08	492.89
Retiree + DP + Retiree's Child(ren)	662.41	920.32
Retiree + DP + DP's Child(ren)	662.41	920.32
Retiree + DP + Children of both	662.41	920.32
To determine your final premium, turn to page 29.		

Non-State Active and Retiree Rates

Effective July 1, 2012 - June 30, 2013

Non-State Active Employee Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Employee Only	846.62	623.98
Employee + Spouse	1,651.57	1,247.96
Employee + Child(ren)	1,229.01	930.55
Employee + Family	2,033.96	1,554.53
To determine your final premium, turn to page 29.		

Non-State Retiree Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Retiree only	836.15	602.01
Retiree + Spouse/DP	1,630.63	1,204.02
Retiree + Child(ren)	1,213.83	864.69
Retiree + Family	2,008.31	1,466.70
Surviving/Unsubsidized Dependent	836.15	602.01
Surviving/Unsubsidized Spouse/DP + Child(ren)	1,213.83	864.69
To determine your final premium, turn to page 29.		

Years of Service Subsidy

State Retiree Subsidy
For Retirees Enrolled in the PPO/HMO Plan

YOS	Subsidy
5	+354.48
6	+319.03
7	+283.58
8	+248.14
9	+212.69
10	+177.24
11	+141.79
12	+106.34
13	+70.90
14	+35.45
15 (Base)	-
16	-35.45
17	-70.90
18	-106.34
19	-141.79
20	-177.24

Non-State Retiree Subsidy
For Retirees Enrolled in the PPO/HMO Plan

YOS	Subsidy
5	-118.16
6	-153.61
7	-189.06
8	-224.50
9	-259.95
10	-295.40
11	-330.85
12	-366.30
13	-401.74
14	-437.19
15 (Base)	-472.64
16	-508.09
17	-543.54
18	-578.98
19	-614.43
20	-649.88

- Participants who retired before January 1, 1994, subtract the 15 year (base) subsidy from the participant premium in the selected plan and tier.
- For participants who retired on or after January 1, 1994, add or subtract the appropriate subsidy above to or from the participant premium in the selected plan and tier. In no case will your premium be less than $0.
- Retirees with less than 15 Years of Service, who were hired by their last employer on or after January 1, 2010 and who are not disabled do not receive a Years of Service Subsidy or Base Subsidy. Employees initially hired on or after January 1, 2012 will not receive the years of service subsidy.
- If you are a retiree (or survivor) enrolled in the PEBP CD PPO HDHP or an HMO plan and you pay for Medicare Part B, **deduct $99.90** from your premium cost. Dependents do not qualify for the Part B credit.

Exchange-HRA Contribution and Optional Dental Coverage

Retirees Enrolled in Extend Health

Exchange-HRA Contribution for Medicare Retirees Enrolled in Extend Health	
Years of Service	**Contribution**
5	+50.00
6	+60.00
7	+70.00
8	+80.00
9	+90.00
10	+100.00
11	+110.00
12	+120.00
13	+130.00
14	+140.00
15 (Base)	+150.00
16	+160.00
17	+170.00
18	+180.00
19	+190.00
20	+200.00

- Extend Health participants who retired before January 1, 1994, receive the base 15 year Exchange-HRA contribution.
- Extend Health participants who retired on or after January 1, 1994, receive the Exchange-HRA contribution that corresponds to the number of years the retiree worked for a Nevada public entity.
- Those retirees with less than 15 Years of Service, who were hired by their last employer on or after January 1, 2010 and who are not disabled do not receive an Exchange-HRA contribution.
- Retirees initially hired on or after January 1, 2012 will not receive an Exchange HRA contribution.

Voluntary Dental Coverage Option

Optional dental coverage for retirees enrolled in an Extend Health Medical Plan

Voluntary Dental Coverage	State Retiree Rate	Non-State Retiree Rate
Retiree only	38.87	30.63
Retiree + Spouse/DP	77.73	61.27
Surviving/Unsubsidized Spouse/DP	38.87	30.63

Retirees and their spouses or domestic partners enrolled in a health care plan offered through Extend Health have the option of purchasing PEBP's dental coverage. To elect PEBP's dental coverage you will need to select Extend Health's medical coverage and PEBP's dental coverage on the Open Enrollment Form. Retirees enrolling in the PEBP PPO Dental Plan effective July 1, 2012 will be responsible to cancel any other dental coverage through Extend Health by June 30, 2012.

Unsubsidized Dependent Rates

For dependents of Medicare Exchange retirees

Effective July 1, 2012 - June 30, 2013

STATE - Unsubsidized Dependent	CD PPO HDHP Plan	HMO
Spouse/Domestic Partner or Child	631.32	602.01
Child(ren)	813.12	863.79
Spouse/DP + Child(ren)	813.12	863.79

NON-STATE Unsubsidized Dependent	CD PPO HDHP Plan	HMO
Child or Spouse/Domestic Partner	836.15	602.01
Children	1,213.83	864.69
Spouse/DP + Child(ren)	1,213.83	864.69

COBRA Rates

State and Non-State Employee or Retiree

	Statewide PPO	Statewide HMO
	Consumer Driven High Deductible Health Plan	**Hometown Health Plan & Health Plan of Nevada**
State Employee or Retiree		
Participant	654.62	624.73
Participant + Spouse/DP	1,266.75	1,249.46
Participant + Child(ren)	848.74	896.35
Participant + Family	1,460.86	1,521.08
Spouse/DP Only	654.62	624.73
Spouse/DP + Child(ren)	848.74	896.35
Non-State Employee or Retiree		
Participant	863.55	636.46
Participant + Spouse/DP	1,684.60	1,272.92
Participant + Child(ren)	1,253.59	949.16
Participant + Family	2,074.64	1,585.62
Spouse/DP Only	863.55	636.46
Spouse/DP + Child(ren)	1,253.59	949.16

-- COBRA participants do not qualify for Life Insurance and Long Term Disability.
-- Participants on COBRA do not receive a subsidy.

PEBP Important Notices

HIPAA Privacy Practices

The Privacy Rule provides federal protection for personal health information and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other purposes. For more information, please visit the following website: http://www.hhs.gov/ocr/office/index.html

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services. This includes all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy, including lymphedema.

If you have questions about coverage of mastectomies and reconstructive surgery, please call your plan administrator for additional information:

- Consumer Driven PPO High Deductible Health Plan: 888-7NEVADA (888-763-8232)
- Health Plan of Nevada: (702) 242-7300 or (800) 777-1840
- Hometown Health Plan: (775) 982-3232 or (800) 336-0123

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). For more information, please visit the following website http://www.dol.gov/index.htm.

CD PPO HDHP Vendor Contact List

Medical, Dental and Pharmacy Contacts

CD PPO HDHP Medical and PPO Dental Claims Administrator • Claim status inquiries • Plan benefit information • HSA/PPO-HRA Administration • Network Providers • ID cards	**HealthSCOPE Benefits** P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 888-7NEVADA 888-763-8232 Group Number: NVPEB www.healthscopebenefits.com
In-State PPO Medical Network • Network Providers • Provider directory • Additions/deletions of providers	**PEBP Statewide PPO Network** Administered by Hometown Health Partners and Sierra Healthcare Options Customer Service: (800) 336-0123 www.pebp.state.nv.us
National Provider Network • For participants who reside in Nevada who access healthcare services outside of Nevada	**First Health Network** P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 800-226-5116 www.myfirsthealth.com
National Provider Network • For participants who reside outside of Nevada who access healthcare services outside of Nevada	**GWH-CIGNA** 1000 Great-West Drive Kennett, MO 63857-3749 888-763-8232 www.myCignaforhealth.com
Dental PPO Network • Statewide dental PPO providers • Dental provider directory	**Diversified Dental Services** Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538
CD PPO HDHP Pharmacy Plan Administrator • Prescription drug information • Retail network pharmacies • Prior authorization • Non-network retail claims payment • Mail order service and mail order forms	**Retail Pharmacy Services** **Catalyst Rx** (800) 799-1012 (702)933-4521 (Las Vegas) **Walgreens Mail Order** (866) 845-3590 www.catalystrx.com User Name: nevada Password: benefit
APS Healthcare • Pre-certification • Case Management	**APS Healthcare** Pre-certification and Customer Service (888) 323-1461 www.apshealthcare.com
U.S. Preventive Medicine • Live Well, Be Well Prevention Plan • Diabetes Care Management • Obesity Care Management Program	**U.S. Preventive Medicine (USPM)** **The Prevention Plan** (877) 800-8144 www.ThePreventionPlan.com

HMO and Voluntary Products Vendor Contact List

Northern HMO Plan • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers	**Hometown Health Plan** Customer Service: (775) 982-3232 or (800) 336-0123 http://stateofnv.hometownhealth.com or www.pebp.state.nv.us
Southern HMO Plan • Provider network • Provider directories • Benefit Information/Appeals • Additions/deletions of providers	**Health Plan of Nevada** Customer Service: (702) 242-7300 (800) 777-1840 www.stateofnvhpnbenefits.com or www.pebp.state.nv.us
Medicare Exchange Medicare supplemental plans and HRA administrator for retirees with Medicare Parts A and B	**Extend Health** Customer Service: (888) 598-7545 www.ExtendHealth.com/PEBP
Life and AD&D Insurance • Life insurance benefits information • Claim filing • MEDEX travel assistance • Beneficiary designation forms	**Standard Insurance Company** Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us
Voluntary Product Contacts	
Life Insurance • Voluntary Life Insurance • Voluntary Short-Term Disability Insurance	**Standard Insurance Company** Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us
Long-Term Care Insurance	**Colonial Life UNUM** Customer Service: (877) 433-5334 www.pebp.state.nv.us
Flexible Spending • Medical • Dependent Care **Enrollment forms:** www.asiflex.com **or** www.pebp.state.nv.us	**ASI Flex** Customer Service: (800) 659-3035 Fax: (866) 381-9682 P.O. Box 6044, Columbia, MO 65205 www.asiflex.com
Home and Auto Insurance	**Liberty Mutual** Customer Service: (800) 637-7026 gary.bishop@libertymutual.com **Travelers'** Customer Service: (888) 695-4640 www.travelers.com/nevada

Plan Year 2013 Open Enrollment Meeting Schedule

May 8	**North Las Vegas**	**Cashman Center** Rooms 101, 102, 103 and 104 850 Las Vegas Blvd.	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 9	**North Las Vegas**	**Cashman Center** Rooms 101, 102, 103 and 104 850 Las Vegas Blvd.	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 14	**Carson City**	**National Guard Auditorium*** 2460 Fairview Drive	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 15	**Carson City**	**National Guard Auditorium*** 2460 Fairview Drive	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 16	**Reno**	**Grand Sierra Resort** **Silver State Rooms S2, S3** 2500 East Second Street (located inside the South entrance on the Arcade floor - across from the Golf Range)	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 17	**Reno**	**Grand Sierra Resort** **Silver State Rooms S2, S3** 2500 East Second Street (located inside the South entrance on the Arcade floor - across from the Golf Range)	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 22	**Winnemucca** *Video-conference*	**NDOT** **Conference Room** 725 W. 4th Street	9:00 a.m. - 11:00 a.m. 1:00 p.m. - 3:00 p.m.
May 22	**Tonopah** *Video-conference*	**NDOT** **Conference Room** 805 S. Main	9:00 a.m. - 11:00 a.m. 1:00 p.m. - 3:00 p.m.
May 23	**Ely** *Video-conference*	**Great Basin College** **Room 112** 2115 Bobcat Drive	9:00 a.m. - 11:00 a.m. 1:00 p.m. - 3:00 p.m.
May 23	**Elko** *Video-conference*	**Great Basin College** **Greenhaw Tech. Arts Building, Room 130** 1500 College Parkway	9:00 a.m. - 11:00 a.m. 1:00 p.m. - 3:00 p.m.

***Photo ID required at entrance**